

MONTHLY INCOME AND EXPENSE REPORT for Region _____**Expense Reimbursement Contract**NumberDescription**DIVISION:** 030**Mental Health, Developmental Disabilities & Addictive Diseases****REPORT CCYYMM:** _____**LOCAL AGENCY:** _____**REPORT BASIS (CASH):** C**BUDGET PROGRAM:** _____**ACCRUAL CCYYMM:** _____**CURRENT EXPENSES**

SCOA	Description	Amount	SCOA	Description	Amount
511.001	Salaries	_____	622.001	Direct Benefits to Clients	_____
511.002	Local Salary Supplement	_____	622.002	Pay For Services/Fixed Rate	_____
511.201	Overtime	_____	622.031	M.R. Work Activity Salaries	_____
513.001	Hourly Labor	_____	622.044	Room and Board	_____
514.001	FICA	_____	622.045	Respite Care	_____
514.002	FICA-Local Supplement	_____	622.046	Training	_____
514.201	FICA-Overtime	_____	622.047	Personal Allowances	_____
515.001	Retirement	_____	627.001	Other Operating Expenses	_____
516.001	Health Insurance	_____	633.001	Computer Software	_____
516.002	Health Ins – Local Supplement	_____	640.001	Travel	_____
516.201	Health Ins – Overtime	_____	640.002	Travel Supplement	_____
517.001	Personal Liability Ins - Employee	_____	641.001	Motor Vehicle Equip Purchases	_____
518.001	Unemployment Insurance	_____	643.001	Equipment (\$1000 or more)	_____
519.001	Workers Compensation	_____	644.001	Lease Purchase of Equipment	_____
520.001	Assessment by Merit System	_____	645.001	Rental of Equipment	_____
612.001	Motor Vehicle Expense	_____	646.001	Equipment (Less than \$1000)	_____
614.001	Supplies and Materials	_____	648.001	Building Rent	_____
614.006	Food Supplies	_____	651.001	Per Diem & Fees	_____
614.018	Pharmaceuticals	_____	653.001	Contracts	_____
615.001	Repairs and Maintenance	_____	673.001	Telecommunications	_____
617.001	Utilities	_____	681.001	Postage	_____
618.001	Printing	_____			
620.001	Insurance and Bonding	_____	TOTAL		_____

FUND SOURCES TO COVER CURRENT EXPENSES

Fund Source	Description	AMOUNT	Fund Source	Description	AMOUNT
6001	County Participating	_____	6021	Other Local Funds	_____
6002	County Cash Match	_____	6024	Prior Year Program Income	_____
6004	County Non-Participating	_____	6028	Medicaid Pharmacy	_____
6006	Municipal	_____	6030	MRDS Work Activity	_____
6008	Outpatient Medicare Fees	_____	6032	Medicaid Waiver CY Fees	_____
6009	Outpatient Medicaid CY Fees	_____	6039	Outpatient Medicaid PY Fees	_____
6013	DOE Contracts	_____	6042	Insurance Reimbursement	_____
6015	Client Fees	_____	6047	Medicaid Waiver PY Fees	_____
6016	Private Insurance	_____	7014	Direct Federal Funds	_____
6017	Other Fees	_____	8001	GRANT-IN-AID	_____
6018	Contracts	_____	8002	DHR Contracts	_____
6020	Hospital Authority	_____	TOTAL		_____

MONTHLY INCOME AND EXPENSE REPORT for Region _____
Expense Reimbursement Contract

Number

Description

DIVISION: 030

Mental Health, Developmental Disabilities & Addictive Diseases

REPORT CCYYMM: _____

LOCAL AGENCY: _____

REPORT BASIS (CASH): C

BUDGET PROGRAM: _____

BUDGET REVISION: _____

AGENCY SIGNATURE	
<p>I certify that to the best of my knowledge, the information on Page 1 of this summary is a true and accurate statement of the revenues and expenses for the specified month.</p>	
<p>_____ Authorized Agency Signature</p>	<p>_____ Date</p>
<p>_____ Title</p>	
DMHDDAD SIGNATURE	
<p>Reviewed By:</p>	
<p>_____ Authorized DMHDDAD Signature</p>	<p>_____ Date</p>